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ABSTRACT

Findings from 185 projects funded by the National Institute of Mental Health are summarized to describe the extent, nature, correlates and consequences of utilizing nonprofessionals in mental health service roles. Paid and volunteer workers were almost equally represented, with females in the majority (56 percent). The majority of projects (59 percent) employed more nonprofessionals than professionals, and the institutional care settings, rather than community settings, had higher ratios of nonprofessionals. Nonprofessional tasks included those formerly carried by professionals, those not performed previously by anyone, and, significantly, those previously thought of as requiring professional competence but redefined in accordance with the capacities of nonprofessional personnel. Implications for planning and practices include recruitment and education of nonprofessionals for a wide spectrum of mental health service functions and greater recruitment of special groups, such as youth, senior citizens, underprivileged, and all ethnic minority groups. A key implication for professional education is that greater clinical diagnostic and treatment skill is needed since the professional is being relieved of time-consuming tasks not requiring professional expertise. (SB)

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Non-Professional Personnel in Mental Health Programs

a survey

THE NATIONAL CLEARINGHOUSE FOR MENTAL HEALTH INFORMATION

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NON-PROFESSIONAL PERSONNEL
IN MENTAL HEALTH PROGRAMS

A Summary Report Based On A Study
Of Projects Supported by the
National Institute of Mental Health
Under Contract No. PH-43-66-967
With Columbia University School of Social Work
Center for Research and Demonstration

Samuel Finestone, Center Director
Francine Sobey, Study Director

November 1969

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This is a summary report of research conducted under Contract No. PH-43-66-967 between the National Institute of Mental Health, Public Health Service, Department of Health, Education and Welfare and the Center for Research and Demonstration of the Columbia University School of Social Work in the period from June 1965 to August 1968.

A pilot study conducted by the first study director, Dr. Yetta Appel, contributed to the formulation of the research. The major leadership and research work was the responsibility of Dr. Francine Sobey, Study Director, from June 1966 to termination. The summary here presented is based on the comprehensive report of findings prepared by Dr. Sobey for NIMH in August of 1968. Appreciation is extended to Mrs. Ann Nichols for major editorial assistance in the preparation of this summary.

Grateful acknowledgement is given to Mrs. Ruth Knee, Chief of the Mental Health Care Administration, for her interest and guidance throughout the study, and to Assistant Dean Samuel Finestone, Director of the Center for Research and Demonstration who, as Principal Investigator for Columbia University, made valuable conceptual and methodological contributions.

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INTRODUCTION

The critical need to expand treatment and preventive programs in the field of mental health, and the shortage of professionals to staff such programs, have required that high priorities be placed upon the exploration and utilization of new sources of manpower. The trend toward innovative roles for paid and volunteer non-professionals has also been influenced by the development of new concepts in the care of the mentally ill, and the need to reach socially disadvantaged populations with mental health programs. During the past decade, the National Institute of Mental Health has supported a number of demonstration projects involving the use of non-professional workers in mental health service roles. This study was stimulated by an interest in the assessment of the contributions of the non-professional workers and a desire to identify the factors that project directors considered most essential to the effective utilization of non-professional personnel.

In June of 1965, at the request of NIMH, the Center for Research and Demonstration of the Columbia University School of Social Work entered into a contract to conduct a small pilot study of non-professional utilization in a limited number of projects supported under the Mental Health Project Grant Program. Pilot

Study 1214, directed by Dr. Yetta Appel, was conceived as a preliminary effort to survey the characteristics and the contributions (as well as the problem areas) in the use of non-professional workers in mental health settings and to test the feasibility of a mail questionnaire approach. The feasibility of a mail questionnaire approach with a large sample was clearly established by the quality and completeness of the responses to the pilot study. The recommendation was therefore made that a larger study (utilizing the mail questionnaire approach) be conducted to expand knowledge of the nature and extent of utilization of non-professionals in NIMH projects.

Accordingly, the decision was made in June 1966 by NIMH to conduct a major survey of current and terminated NIMH projects which involved service roles for non-professionals. The broad purpose of this study was to gather and analyze comprehensive factual information about the number of characteristics of non-professional staffs, the nature of their utilization, and the directions indicated for their future utilization. A comprehensive report of the entire survey, directed by Dr. Francine Sobey, was submitted to NIMH in August of 1968, and the present document constitutes a summary of that report.

In the earliest development of the research, a paper entitled "The Utilization of Non-Professional Personnel in Service Roles in the Provision of Mental Health Services: An Exploratory Assessment" was prepared by Dr. Yetta Appel in an effort to study certain key issues and to develop a typology of service functions for non-professionals based on their utilization in mental health service as a whole. The content of this paper, distributed to mental health and related facilities throughout the country, has been incorporated into Section I of this report. For the major survey under government contract, the conceptual base of the research was expanded in July 1966 by Dr. Sobey to include the issue of non-professional utilization in relation to project goals and concepts of preventive intervention in the field of mental health.

During the course of the research, extensive bibliography was compiled. The National Clearinghouse for Mental Health Information had a prior interest in bibliographical study on volunteers in mental health. As a result of joint planning within NIMH, the Clearinghouse contracted with the Center for Research and Demonstration for a publication titled "Annotated Bibliography on Volunteers in Mental Health." Thus, some of the literature reviewed for the purpose of the project became part of the material produced for the Clearinghouse. Nearly 500 articles and documents were abstracted and incorporated in the computerized information retrieval system of the Clearinghouse.

A further development is a forthcoming publication which interprets research findings against the background of the Nation's mental health crisis, and presents a timely analysis of power relationships and other crucial issues in non-professional utilization for the 1970's.[1]

The summary which follows highlights major findings and implications of the research project on non-professionals in NIMH supported projects. Section I discusses the relevant background trends and issues related to the use of non-professionals. A brief statement of the scope and strategy of the survey follows in Section II. Section III is devoted to the findings of the survey, and Section IV gives implications for future planning, programs, and research. An extensive bibliography reviewed in the course of the study is appended. It is hoped that the limitations inherent in the task of abstracting findings from an extensive three year research study will be considered carefully in studying this report.

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[1] Sobey, Francine S., The Non-Professional Revolution in Mental Health: Columbia University Press, 1970.

Section One

ISSUES IN MENTAL HEALTH SERVICE DELIVERY AND MANPOWER UTILIZATION

The use of non-professionals in mental health services can be understood better by considering the broad trends influencing the entire field of mental health. A variety of social and professional changes have led to expanded use of non-professionals in service roles.

Social Trends

A cluster of social-demographic factors contribute to the increasing demand for mental health services. While there has been rapid population growth, the mental health professions have not produced a proportionate increase in trained personnel. The growth in population has brought significant changes in the distribution of people in various age categories. For example, the proportion of persons in the highly dependent categories (under 18 and over 65) has become significantly greater. This shift has created the need for expanded services for the minor and aged groups.

Our society also has been undergoing profound socio-economic transformations: urbanization, industrialization, mobility, specialization, bureaucratization, and an accelerated rate of social change. Industrialization and technological advances have changed the structure of employment opportunities. There has been a shift from a predominant blue-collar work force to one dominated by white-collar, skilled, service-oriented, and professional positions. Moreover, those occupations requiring the highest levels of education and training have had the fastest rate of growth.

Effects of urbanization and mobility are apparent in many facets of American life. Social interactions tend to be more impersonal and superficial in large cities. Mobility leads to relationships which are transitory, and contribute to the relative isolation of individuals and families. The primary group supports provided by extended family living in relatively stable neighborhoods or small communities are today less available. Moreover, the shift from the extended to the nuclear type of family organization has not reduced the need for primary social supports--if anything, this need is intensified in an urban environment.

The interaction of these demographic and social factors often produces new stresses. The breakdown of the extended family pattern has intensified the isolation of the aged and has increased their need for social services. Business policies frequently force a person into retirement while he still is productive and eager to work.

Another social-demographic trend affecting the demand for mental health service is the widening gap between the affluent and the poor in our society. The poor suffer not only material deprivation, but also are deprived of the benefits of social, medical, and psychological knowledge and services.

In the last fifteen years we have witnessed a public awakening to and an acknowledgement of the extent and severity of economic deprivation in our country. Not only have the poor had less access to personalized social services but their needs in education, housing, employment, and health have not been met. During this period, a broad-based and activist civil rights movement developed. Although this movement began by focusing on laws which permitted segregation and denied equal access and opportunity, by the mid-1960's it was deeply concerned with the problem of poverty both in the ghettos and in the rural areas of the South.

The "War on Poverty" was one of the Federal government's major responses to the problems of the poor. Its policies recognized the necessity to redistribute programs and services and to utilize the poor themselves in this endeavor. The ideas of self-determination and self-help were common elements in anti-poverty legislation.

In the last few years, the civil rights movement has become increasingly militant, and political involvement and self-determination have become priority goals. More and more recognition is given to the need to involve the poor in the solution of their problem and to develop indigenous leadership.

Although the extension of employment opportunities is a major objective in anti-poverty programs, there is a scarcity of unskilled jobs. The poor -- usually undereducated and without special skills -- have difficulty finding positions in the skilled labor market. However, the need is great for workers in the service fields: health, education, and welfare. The "New Careers" movement has shown that job opportunities for the poor exist if we redefine work responsibilities in many of the service professions. Special training programs have been instituted to prepare case aides, neighborhood health workers, homemaker aides, laboratory assistants, recreation aides, and other similar workers. The New Careers idea seeks to provide programs for adequate preparation, lines of advancement, remuneration, and job security.

Changing Concepts of Mental Health and Treatment

Changing concepts of mental health and treatment have had an important impact on the determination of manpower requirements and roles. In the last two decades environmental factors have received greater attention. The organizational structure of mental health services, staff interrelationships, problems of status and role differentiation and the social distance between staff and patients have been studied to determine their effect on the rehabilitation of the mentally ill.

These studies played a part in the introduction of "milieu therapy" or the "therapeutic community" which features group and individual counseling, patient self-government, retraining in such everyday activities as personal hygiene, shopping, and communicating with others. In this situation, since the non-professional often has the most extended contact with the patient and influences the patient's immediate environment, it was only natural that psychiatric aides, ward attendants, recreational aides and community volunteers would be given greater status. The rehabilitative, rather than the custodial functions of the non-professional, have been given greater emphasis. Thus, instead of being peripheral to the mental health team, the non-professional has become increasingly an integral part of it.

Patients in mental hospitals tend to adapt to the institution and the longer their confinement the more difficult the readjustment. Awareness of this led to new patterns of treatment which minimized the period of hospitalization or eliminated it altogether. Facilities within the community, whether structured as outpatient services, clinics, or the psychiatric ward of general hospitals, now are more readily available. Various models for treatment within these settings are based on the recognition that problems of mental illness vary among different individuals or social groups. Probably, the most familiar treatment model is clinical intervention by a

professional. Because of shortage of such personnel, this intervention may involve primarily diagnostic assessment, evaluation, and treatment planning.

Clinical intervention is still the preferred treatment model for those suffering acute mental illness and acute stress reaction. Yet those who are severely ill emotionally, actively delinquent, or seriously disorganized in their functioning need to be provided with rehabilitative treatment. Their problems are chronic and multiple in nature, and treatment models characterized by a discrete, limited approach are not relevant to their needs.

To reverse these chronic dysfunctional disabilities, many advocate a treatment model which develops "social competence." This kind of treatment offers wide possibilities for the use of non-professionals. Essentially, social competence involves the development of skills to enable individuals to function more effectively and to cope with their social environment by substituting functional ego skills to replace dysfunctional responses. This approach represents a significant change in traditional therapeutic goals. The personnel needed to implement such an approach are those who can teach effective, successful coping techniques through a combination of a direct educational approach, supportive help, and by provision of ego models.

Emphasis on social competence and self-help has implications for the structuring of treatment and the use of non-professionals. This concept envisions a person extending aid to another who shares the same problem or lives under the same conditions. In this way, not only is the therapeutic process aided by common experience, but the helper benefits as he reinforces positive patterns of behavior.

The need of individuals and population groups has influenced not only the treatment services but also the treatment models. It is no longer considered adequate to concentrate resources on the mentally ill--priority must be given to programs of prevention. The field may be seen to encompass a continuum from mental health to mental illness. This model incorporates three levels of prevention--primary, secondary, and tertiary. The goal of tertiary prevention is to provide treatment to those already seriously ill which will limit disabilities and minimize the possibility of chronic impairment. Secondary prevention is concerned with the availability of detection services and services to intervene effectively at an early stage to prevent the development of more serious disturbances. In primary prevention, there is an emphasis on the goal of systematically promoting the general mental health of the whole community.

The focus of primary preventive work is increasingly on community planning. The Community Mental Health Centers Act of 1963 has led to a concern with both high-risk and "well" populations--the 90 percent in need of practical mental health information and assistance. Ecological and crisis theories formulated by mental health investigators such as Eric Lindeman, Erikson, and Gerald Caplan provide a framework for design of programs to help people cope with normal developmental life crises (e.g. childbirth and school entry) and crucial accidental life crises (e.g. an infant's loss of its mother or a wage earner's loss of job).

Another concept reflective of an area of concern in the current structure of services is that of "continuity of care." Fragmentation, specialization, and lack of integration are characteristics of our social services. Effective care requires continuity in service and treatment relationships. It is particularly relevant to chronic problems such as juvenile delinquency, long-term mental illness, and family dependency and disorganization. Individuals and families who suffer these pervasive disabilities appear to be in particular need of consistent and enduring social supports and a comprehensive form of rehabilitation.

The changing concepts of mental health and treatment described briefly above suggest a variety of rationales for the use of

non-professional workers. For example, preventive mental health work among chronically needy families will require not only additional personnel, but skills which are not part of the typical repertoire of the professional. Providing long-term social support may be seen a logical province for the indigenous worker and other non-professionals.

Professional and Non-Professional Functions

There is general agreement that major deterrents to the extension of essential mental health services are the continuing, acute professional manpower shortages and the less than adequate deployment of the available manpower. The increased utilization of non-professional personnel in a variety of roles had been considered to be basically related to shortage of professionals, and as such has been seen primarily as a pragmatic response to meet pressing service needs. However, in recent years there has been an increasing acknowledgement of the "unique" contribution of the paid or volunteer non-professional as an intrinsically valuable mental-health manpower resource; in this context, the programming of non-professional staff positions has been a planned response to new concepts of treatment.

The two rationales mentioned above for the use of non-professionals could be described as the "expedient" and the "unique" formulations. In the first case, the roles and responsibilities of the non-professional proceed from the professional's definition of what is needed. Attention centers on analyzing the professional role in order to determine which functions, or components, can be performed by those with less than professional training. This type of concept of the use of the non-professional could be termed "additive," as contrasted with the redesign of the program model when the non-professional is seen as unique. In this second case, the non-professional may perform adjunctive tasks but will also be involved in significant new roles such as "reaching out" to isolated and deprived individuals, rendering primary social support and teaching improved social relations, etc.

The "unique" contribution of the non-professional is particularly evident in plans for primary prevention. Among such preventive roles are the paid or volunteer teacher-mom who provides a needed relationship of warmth, learning, and counseling to a socially deprived child; the mental health agent in a store-front agency who helps poor families with the daily stresses of living; the foster grandparent who cares regularly for the neglected child; the community organizer who enlists aged citizens in vital community improvement programs; and the homemaker who keeps the family and home intact when a mother becomes ill.

Typology of Service Functions for Non-Professionals

The greater use of non-professionals has increased the need for a more systematic analysis of the contribution of the non-professional worker. The following typology of service functions for non-professionals represents an attempt at classification based on observation of current utilization practices:

* the caretaking function, which includes the provision of physical care and supervision as, for example, in institutional care, or foster homes, or by a homemaker;

* the bridging function, which helps make the connection between the person in need and sources of help through interpreting, expediting, and linking activities;

* the sustenance, or social support, function which may be provided through "substitute personal relationships"; and

* the professional assistant function, i.e., serving as an aide, or assistant, and functioning in a closely adjunctive manner to the professional, and under his direct supervision; this may include counseling activity approaching professional therapeutic intervention.

It is difficult to delineate these functions for the non-professional engaged in a service role for he may well find himself at various times with the same patient, or client, functioning in several, or all, of these ways. Nevertheless, it is evident that certain functions are significantly more related to some roles than to others. The psychiatric aide or ward attendant is more likely to provide physical care and/or supervision than the non-professional functioning as a case aide, and it is likely to be the volunteer who more usually provides a substitute personal relationship.

Some of these functions, of course, are found in the professional's relationship to his client. However, the particular skills and functions of a trained professional are a scarce resource and much in demand. Thus, the strategic deployment of non-professionals in well-planned service roles will free the professional from some tasks which do not require professional training; the work of the non-professional will also enable the client to be more receptive to and to better utilize professional intervention.

As the job function of non-professionals is widened and they assume greater responsibilities, there will be strains in their relationships with professionals. Certainly this will happen when training and job responsibilities are similar. Where there is little differentiation in function, but only in level of supervision and remuneration; status and power concerns will naturally arise. The development of teams is one approach to improving interrelationships and fostering greater integration. Such teams of professionals

and non-professionals can be structured to develop a relationship network to provide the needed range of services. Rather than using the single case or task for allocation of responsibilities, a cluster of activities based on specified objectives may be outlined for the entire team. With this approach, the professional presumably would be able to provide the kind of professional intervention he is particularly equipped to give in a wider range of cases, since he would not be dissipating his energies on services that might be better performed in the long run by non-professionals.

Section Two

SCOPE AND STRATEGY OF THE SURVEY

Introduction

This report represents a summary of findings from 185 projects funded by the NIMH because of their intent to explore innovative approaches to mental health services or to improve existing services. These projects were developed in a wide range of settings throughout the United States. They had one common characteristic; namely, they elected to use paid or volunteer non-professional personnel to deliver mental health services. This report is primarily based on a descriptive and explanatory study in an area which is just beginning to be systematically explored. The practical aim of the study is to describe the extent, nature, correlates, and consequences of utilization of non-professionals in mental health service roles in innovative mental health programs. Major study questions include the following:

Questions of the Study

1. The nature and extent of non-professional utilization.

* To what extent are paid and volunteer non-professionals used in these experimental mental health projects? What are their numbers, their titles, and the ratio of non-professional to professional numbers and hours of work?

* What are their characteristics? Do they belong predominantly to any particular sex, age group, ethnic group, educational level? To what extent are they the "indigenous" non-professionals?

* What is the nature of their use? What are the functions or tasks allocated to them? How are they recruited, trained, and supervised in the performance of these tasks?

2. Project characteristics.

* What is the nature of the settings, geographic location, and auspices of the projects in which non-professionals work?

* With which professional disciplines and programs are they working?

* Who are the patient-client populations to which they are addressing their services?

* What types of care are they helping to provide?

3. Correlates of non-professional utilization.

* Are there significant relationships between non-professional usage and certain types of settings, locations, and project goals?

* Can significant relationships be found between non-professional utilization and innovative and preventive activity in the mental health projects?

4. Consequences of non-professional use.

* What is the non-professional's contribution to project objectives?

* How is his overall performance assessed by project directors?

* What problems are identified by project directors in the use of non-professionals?

In addition, a second level of inquiry was addressed to the issue of what these projects were doing to prevent mental illness and related social problems. How non-professionals were being used in this preventive context received special attention.

By classifying project goals along the public health continuum of primary, secondary and tertiary prevention, and describing innovation along several dimensions, a picture emerged of the nature and extent of preventive and innovative efforts in the mental health projects. An effort was made in this inquiry to clarify and specify the concepts of levels of preventive intervention in mental health. It is hoped that roles of non-professionals in prevention and innovation can now be considered with greater understanding.

Definitions

For the purposes of the study, *non-professionals were defined as those persons (paid or volunteer) who provided a direct service to individuals, groups of patients/clients, or community groups, and involving some degree of patient/client contact, but who do not have, or have not completed, any formal mental health professional training*. *Volunteers were those persons who offered services without fixed* remuneration, either salaries or stipends. Non-professional clerical, administrative, or maintenance personnel were not included, unless they performed direct service functions.

The mental health projects were those funded by either the Mental Health Project Grant Program or the Hospital Improvement Project Grant Program of the NIMH. They were based in a variety of community settings and in state mental hospitals. In some cases the projects were funded primarily to experiment with new manpower uses while in other cases non-professional utilization became instrumental in testing out new forms of service-delivery or reaching out to new groups needing care.

The sample, more properly termed a universe, was defined for the purposes of the survey as every NIMH project supported by a grant from one of the two grants programs mentioned above which used non-professionals in mental health service tasks, in the period beginning January 1, 1960 to August 1, 1967, and in operation for at least six months. This universe of projects was identified in a joint undertaking between the offices of NIMH in Bethesda, Maryland, and the Center for Research and Demonstration of Columbia University School of Social Work, and it included 286 NIMH projects.

Data Collection and Analysis

The major questions listed above provided the basis for what eventually became a seventeen page questionnaire. The instrument was pre-tested with a sub-sample. Twentyeight site visits were made for in-depth study of the variety of issues underlying the study, with the purpose of pretesting the substantive adequacy and clarity of the questionnaire. The site visits contributed, therefore, to the instrument construction as well as to the later interpretation of survey data.

In July of 1967, the questionnaires were mailed to the directors of the 286 NIMH projects previously identified. The respondents were advised to return questionnaires if no non-professional personnel were utilized in service roles in the project. Seventy-three projects fell into this group, and were screened out of the study. Of the remaining 213, 28 did not respond to repeated inquiries, leaving 185 projects as the final sample forming the basis for the study. Analysis of known characteristics of the 28 projects not responding led to the conclusion that no significant change in the findings could be expected by non-inclusion of this group.

Incompleteness or inconsistency in responses of the final sample was handled by return of questionnaires or of Xeroxed copies of relevant portions, together with requests for additional information or clarification. This device improved the quality of responses considerably.

Following a process of editing and coding of questionnaire responses, data were transferred to IBM punch cards, and suitable programs worked out for computer tabulation and cross-tabulation of key variables and variable combinations. The major lines of analysis are made clear in the chapters which follow.

Section Three

SURVEY FINDINGS

Introduction

The findings of this research range from descriptive, previously unknown facts of a relatively simple nature to complex data of an explanatory and analytic nature. Obviously, a summary of this type lends itself more readily to reporting of selected highlights of this hard data rather than presentation of the more complicated, conceptual findings.

The theoretical model, which provided the orientation for these research findings, offered a broad framework within which non-professional functioning was singled out for special focus, described, and explained against the backdrop of the total mental health field, and professional functioning in particular.[1]

First the description of non-professionals -- their numbers, their numerous titles, and characteristics in terms of age, sex, ethnic groups, indigenousness, etc. was sought and treated as one of the primary dependent variables of the study. The tasks allocated to non-professionals, and the nature of their recruitment, training and supervision, were closely related variables of importance. The interrelationships within this cluster of variables- -i.e. whether different categories of staff performed the same or different tasks, or whether recruitment methods differed between paid and volunteer staff, were studied by means of construction of charts which, filled in by respondents, gave a wealth of data broken down by staff titles, paid and/or volunteer. Thus, similarities and differences between paid and volunteer non-professionals were highlighted throughout the research.

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[1] The model -- a preventive, socio-medical one, developed from the public health field, and adapted to mental health, is elaborated fully in the original research on which this summary is based. For full understanding of the model, the reader is referred to Francine S. Sobey, The Non-Professional Revolution in Mental Health, Columbia University Press, N.Y., 1970.

Second, the basic characteristics of the projects themselves, whether they were currently operating, or terminated, their geographic location, auspices, professional staffing, constituted another important cluster of independent variables considered highly relevant to an understanding of non-professional usage.

On a more complex level of research, the subject of project goals was studied intensively in the course of specifically locating, and labelling as such, each project's goals illustrative of different levels of prevention. Respondents were asked to rate the amount of emphasis placed by the project on each goal operationalized in terms of its relevance to the public health schema of prevention, treatment and rehabilitation. The study orientation to normality as well as pathology, to project populations more recently considered in need of mental health care -- i.e. the very young and the aged, the "high-risk" populations such as the underprivileged, school drop-outs, or even an entire community, etc. and newer types of care appropriate for these groups -- is hopefully reflected in the capsule findings selected from the original research.

Project Characteristics

The 185 projects are spread throughout the country; with 62 in the Northeast, somewhat over 40 in the North Central and Southern regions alike, just over 20 in the West Pacific and 16 in the West Mountain region. While about one-third of the projects are found in metropolitan areas with population over a half million, the remainder are evenly spread among categories of communities with less population; and indeed nearly one-fifth are in communities under 2500.

Most (113) of the projects were funded under the Mental Health Grants Program, and were operating in a very wide range of settings; most frequently psychiatric hospitals, but also schools, social agencies, settlement houses, community mental health clinics, public health facilities, general hospitals, rehabilitation centers, community organizations, etc. in that approximate order of frequency. Half of these were sponsored by state and local government agencies, the other half by voluntary agencies or other auspices.

The Hospital Improvement Grants Program funded the remaining 72 projects. These were overwhelmingly in psychiatric hospitals (65) with a few other types of medical settings represented, and were all sponsored by state agencies.

Taken together, the 185 projects range widely in location, size of population served and type of agency setting.

Non-Professional Staff Characteristics

Number and Titles. Paid and volunteer workers are almost equally represented among the more than ten thousand non-professionals represented in this survey. Females are in the majority (56% overall) with a slightly higher percentage in the paid group of non-professionals (58%) than in the volunteer group (53%). Males predominate in a few staff categories, notably case aides and volunteers who are professionally trained in other than the core mental health disciplines. Certain job titles--tutor-teacher aide, recreation-group work aide, nursing and ward aide--account for a large percentage of staff (refer to Table 1).

Ratio of Non-Professionals to Professionals. The majority of projects (59%) employed more non-professionals than professionals. Taking all projects together, the average ratio of non-professionals to professionals is 6 to 1. In hours worked, the ratio of non-professionals to professionals was even higher (8 to 1). High ratios of use of non-professionals were not limited to the largest metropolitan cities. The institutional care settings, rather than the community settings, characteristically had higher ratios of non-professionals, reflecting a long-standing pattern of employment of such personnel in residential settings.

Age Trends. Adults (over 21) and young adults (18-21) predominate among non-professionals. There is limited use of adolescents and the aged, and this is noteworthy because these groups are increasing in the population. Special roles for youth and senior citizens were revealed, however.

Recreation and community mental health aide were the positions most often held by adolescents; specific functions in different projects included tutoring, teaching home management

TABLE 1. Distribution by Non-Professional Job Title.

Job Title	Percent	Number of Non-professionals
Tutor Teacher-Aides[a]*	21.7	2,267
Recreation & Group Work Aides[b]*	20.0	2,092
Nursing & Ward Personnel*	16.9	1,758
Other Job Titles[c] (other than listed)*	10.8	1,122
Home Visitors-Enablers	9.8	1,020
Case Aides *	6.4	666
Physical, Occupational Voc. Rehab. Aides*	3.4	355
Neighborhood Community Organizers	2.8	293
Special Skill Instructors	2.7	279
Community Mental Health Aides	2.6	268
Reach-out Aides	1.8	185
Foster Parents	0.6	60
Homemaker *	0.5	52
Total Staff	100.0	10,417

a. One project in an urban ghetto accounted for 1798 tutors, mainly of high school age.

b. This group was characterized by a heavy proportion of volunteer non-professionals.

c. Other titles specified by respondents included Social Workers without M.S.S. degree, Alcoholic Anonymous, Cadre workers, "teacher-moms," etc.

* Starred job titles were pre-listed; the other categories were organized from titles supplied by respondents.

skills to elderly patients, and leading activity groups. Those projects utilizing non-professionals over the age of 65 praised their contributions as case aides, home visitors, rehabilitation aides, tutors, and recreation aides. Most of this over 65 group served as volunteers rather than paid non-professionals.

Educational Characteristics. Considering all staff categories, the majority of projects report that their non-professionals were at least high school graduates, with or without some college study; approximately one-third of the projects utilized staff who did not graduate from high school. Case aides, recreation workers, occupational therapist aides, and tutors are characterized by high education levels, while most of the other staff categories reveal a more even distribution between high and low educational levels. Those with less than high school were found to be an important untapped manpower source.

Ethnic and Indigenous Factors. White personnel predominate in both paid and volunteer jobs, with blacks as the second largest ethnic group reported among paid non-professional staff. As volunteers, however, Negroes were identified as a predominant group in only a few projects. Mexicans, Puerto Ricans, and other groups were represented in regions of the country in which they are heavily represented. About 40% of the projects used staff defined as "indigenous"; that is, persons with problems similar to the project populations--ex-addicts, former mental patients, or persons having similar socio-economic characteristics such as low income, similar racial, or educational backgrounds.

Non-Professional Functions

For purposes of analysis, non-professional functions were organized into three major categories (and their sub-categories) as follows:

1. Therapeutic Functions: This included individual counseling, group counseling, socializing relationships, activity group therapy, milieu therapy, and other therapeutic functions which could be specified by respondents.
2. Special Skill Functions: This included tutoring, various types of retraining, and other special skills which could be specified by respondents.
3. Community Adjustment Functions: This included job and home finding, facilitating access to community services, and other means of adjustment to be specified.

In addition to these major categories, the following five specific functions or tasks were listed which were not easily placed under the above three major categories.

1. Case finding and facilitation of access to project services.
2. Reception orientation to service.
3. Screening (non-clerical) referring to assessment of suitability of patients/clients for service offered.
4. Caretaking; for example, ward care and day care.
5. Community improvement.

An unusually wide range of functions was performed by all non-professional staff. Particularly significant were the "innovative" functions--that is, functions not previously performed by non-professionals in the particular setting. The range of tasks extended from case-finding to general community improvement. The newer social relationship therapies for individuals and groups led the list of most performed functions. Although professionals and non-professionals were found to be working together on similar therapeutic and community tasks, certain functions tend to be performed mainly by professionals. Responsibility for diagnostic knowledge, needed in "screening" and therapy, appears to rest with the professional, and the overall charge of teaching, training and supervising non-professionals is assigned to professionals.

Project Populations and Types of Care Given

The typical recipient of service from the projects studied was found to be a poor, mentally ill adult, with less than high school education. Pre- or post-hospital care, at a state hospital, day hospital, or half-way house was generally given. Major emphases were on personal counseling, habit retraining, social rehabilitation, sheltered work-shop, job and home finding.

Another important but less represented group was the community populations with social problems--the culturally deprived, school-dropouts, and entire communities in need of resource-aid. Child-centered, family-centered, and society-centered preventive programs were offered to these groups.

Agencies have begun to reach out to new groups of people needing service in addition to those with which they have been traditionally concerned, and to use new techniques of service. One finds settlement houses giving after-school activity therapy programs for disturbed children in a slum area rather than the usual recreational care. Educational facilities are providing out-patient care to drug addicts. Projects in traditional case-work agencies are offering broad community development programs rather than one-to-one relationship between caseworker and needy client. State hospital projects are providing "industrial therapy" in cooperation with representatives of community business firms and vocational agencies. Thus, the type of setting--hospital, clinic, social agency, school--is less likely to be an accurate guide to the types of groups served or the modes of service provided.

Recruitment, Training and Supervision

Mental health professionals spent one-fifth of their time in the recruitment, training, and supervision of non-professional personnel. The most frequent methods used to recruit paid non-professionals were employment agencies, advertisements in news media, and recommendations by project professionals and non-professionals. Recommendation by professional and non-professional workers was the method which seems to have achieved the most widespread popularity and success. The primary method used to recruit volunteers was talks to community-volunteer and other groups.

Very few projects provide a basically didactic training program for their non-professionals. Projects use either on-the-job apprentice-type training or use this in combination with didactic instruction. The pattern for paid and volunteer staff is fairly similar. However, a larger proportion of the paid staff used the combined didactic and on-the-job approach.

Only a small number of projects indicated that there was no training after orientation. These, however, tended to apply only to a few staff categories, such as recreation aide, physical, occupational, or vocational rehabilitation aide, and special skills instructor. One possible explanation for this phenomenon is that non-professionals in these categories are often of a high educational level and already trained, thus, requiring less formal direction on the job.

Approximately one-third of the projects indicated that they employed special training methods. These methods are obviously closely related to the nature of the individual project and the functions of its non-professionals. These methods included project staff workshops, monthly in-service meetings, weekly staff meetings for all project staff, daily staff conferences for non-professionals, and training during group sessions with patients, non-professionals, and professionals present.

In addition to these staff meetings and conferences, whether group or individual, many projects used special training methods recently made possible through audio-visual devices. Such devices as tape recorders, closed circuit video tapes of patients and therapists, motion pictures, and one-way vision screens were mentioned by a number of projects. These techniques were rarely used alone, but rather in conjunction with a variety of other techniques.

The large majority of projects hiring non-professionals, regardless of the staff category, provide regular supervision. A small number of projects provided occasional supervision, and an inconsequential number provide supervision only if an emergency arises.

Project Goals, "Preventive Activity" and Innovation

Intensive study and classification of project goals led, in the latter period of the research project, to the development of a preventive index which was aimed at considering not only the "preventive" nature of project goals, but also other variables deemed important--for example, whether younger as well as older persons were served, whether "normal" groups as well as clinically diagnosed populations were being reached, and the extent to which certain specifically designated activities of a "preventive" nature, and certain types of care were being provided by the individual projects. This involved complex, conceptual study and the development of an appropriate methodology, the strategy of which is not suitable for presentation here.[1] Suffice to say that the five chosen variables were found to be statistically interrelated. Based on index scores for each project, it was found that three-fourths of the projects scored medium or highly preventive. Efforts devoted to shortening hospital stays, providing alternatives to hospitalization, and preventing re-hospitalization helped to raise preventive index scores for the many projects which concentrated on treating only those who are mentally ill.

The great majority of projects concentrated primarily on treating severely and chronically ill persons. Comparatively fewer concentrated on efforts to promote community mental health for the general public or to locate early cases of mental or social disorder. The goals of stimulating citizen participation and social action were never ends in and of themselves, but rather instruments in carrying out primary, secondary or tertiary prevention goals. On the strength of this material the inexhaustible suggestiveness of which cannot be conveyed in a summary,[2] the research led to a number of conclusions. One, most relevant to the use of non-professionals in mental health, is that although the secondary prevention goal of locating milder cases of disability to prevent more serious disability, has been considered an urgent national goal, few projects focussed primarily on this goal, and as a result there was limited non-professional participation on this level. However, when non-professionals and volunteers were allowed to participate in finding early cases of disorder, they played interesting and important new social and educational roles.

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[1] Full understanding of methodology and findings can be found in Francine S. Sobey, The Non-Professional Revolution in Mental Health, Columbia University Press, 1970.

[2] Ibid.

An index measuring innovation (first time use by the individual project) was devised to take into account all newer types of care, new groups served, and new uses of non-professionals. Innovations ranged from groups served for the first time (e.g., school dropouts) to new services (day hospitals, home care, foster care) and recruitment of "new" groups of non-professionals. Three-fourths of the projects were considered moderately or highly innovative according to the criteria devised in the study.

Assessment of Utilization of Non-Professionals

The overwhelming majority of projects reported that the advantages of using paid and volunteer non-professional staff greatly outweighed the disadvantages. Strong recommendations were made for their future utilization in mental health service programs.

Most of the projects reported multiple reasons for use of non-professionals; principally, the need to extend service programs, and the professional manpower shortage. Contrary to predictions, the most frequently mentioned single reason for using non-professionals was the need to "provide informal sustaining relationships to patients and clients" (70% of the projects). As society becomes more impersonal, urbanized and automated, the need increases for personal and socializing relationships which the non-professional person is able to provide to the mentally ill and to various community groups--poor and undereducated adults, deprived children, the aged. A close second reason expressed was to relieve the professional of tasks not requiring professional expertise (66% of the projects).

Almost 60% of the projects used non-professionals because they felt they could communicate better with the patient-client groups or reduce the oft-cited problems of "social distance" between professional and patient group.

A significant percentage of the projects (57%) were concerned with some way of stimulating volunteer activity, either for the purpose of increasing general citizen participation in community service programs or improving community understanding of mental health programs.

Comparatively few (40%) reported the use of non-professionals to provide services which would be better provided by professional staff if enough were available (most "expedient" reason). One-half of the projects were concerned with training for new service functions and about one-third with recruiting and training of persons not previously considered eligible for careers in the human services field.

Non-professionals were viewed as contributing to mental health in two unique ways:

1. By filling new roles based on patient needs which were previously unfilled by any staff.
2. By performing parts of tasks previously performed by professionals, but tailoring the task to the non-professional's abilities. The result is that the task gestalt becomes "unique" to the non-professional.

The non-professional's contribution was most substantial toward the project goal of treating and rehabilitating the mentally ill (tertiary prevention). In hospital settings, non-professionals freed professionals for therapeutic tasks which clearly required professional expertise. The non-professional contributed fresh viewpoints in the course of providing "new services" to more people in need.

There were indications that the introduction of non-professionals into an agency for the first time, or in new roles, affected the interpersonal and social systems of the project, both negatively and positively. New problems arose. Overlapping roles, communication and status strains, although not substantially reported, were significant considerations. Generally, the introduction of non-professionals offered the programs new vitality, and forced a self-evaluation which, although painful, were considered to lead to beneficial changes for the programs.

Close to 90% of respondents surveyed indicated that their projects could not have functioned without the utilization of the non-professional group.

Section Four

SURVEY IMPLICATIONS

Planning and Practice in Mental Health

This survey reveals that significant steps have been taken in a greater utilization of non-professionals for a wide spectrum of therapeutic and community improvement tasks. These innovative steps present numerous possibilities for new directions in alleviating mental health manpower shortages.

Sharp boundary lines between the core mental health professional disciplines are no longer visible and in turn, there is less evidence of some of the traditional divisions between professional and non-professional functions. Inevitably, among the different non-professional aide groups, the dividing lines are becoming equally faint. Non-professional social work aides, psychiatric technicians, are performing caretaking, therapeutic, and community-oriented functions with little concern that they are moving out of their traditional roles. Rather, task-functions are being approached with evidence that major emphasis is placed on the patient and the problem.

Some possibilities suggested by the survey include the following:

Recruitment and education of non-professionals for a wide spectrum of mental health service functions. Some projects revealed dramatic evidence that untrained persons could develop skill in observation of symptoms and ability to deliver personalized direct care for the mentally ill. One demonstration project, with built-in research, reported that 80 percent of the non-professionals trained as practical nurses were evaluated as capable of functioning in therapeutic roles in the care of the mentally ill. When non-professionals worked with "normal" populations in the community, skills in community organization and in bridging the gap between the professional and the community were frequently noted. For the more innovative roles which non-professionals were so often asked to assume (e.g., the teacher-mom, home-visitor, reach-out aide), the flexibility of non-professionals was seen as a primary asset. Generally, project directors reported that their non-professionals were ready and willing to learn, to act, and to undertake more than was expected of them.

Greater recruitment of special groups--the youth, senior citizens, the underprivileged, all ethnic minority groups, the indigenous, and the hardcore unemployed.

The evidence clearly shows that retired persons over 65 are an important untapped human service resource. Tremendously underutilized as a group, retired persons have great potential for understanding others in need, and solving many of the practical problems of living (in one project retired homeowners were found to be invaluable in locating homes in a rural area for mentally ill patients who were ready for hospital discharge). The ease of recruiting the retired suggests that elder retired citizens readily perceive mental health service jobs as a way of combatting boredom and enriching their lives. Modification of Social Security restrictions on earnings for the over-65 age group could increase the manpower pool of paid as well as volunteer non-professionals in mental health.

Young people, too, are underutilized even in experimental mental health projects. Exploration of human service careers should be encouraged in schools. Junior high schools and high schools should offer opportunity for young people to develop interest in understanding and helping people in need long before they are ready to enter the labor market. Study findings show that youths of 15 and 16 can make substantial contributions to mental health on two levels: (1) Through direct service to the mentally ill and to underprivileged groups; and (2) indirectly, by offering the entire interpersonal system of mental health projects a new vitality and spontaneity which can energize the performance of older workers--professionals and non-professionals.

A possible dent could be made in the high youth and minority unemployment figures if substantial numbers of unfilled jobs could be filled by these groups. Certainly, these jobs are not in danger of becoming eliminated through automation. Selective experiments in the utilization of the hard-core unemployed currently being undertaken by industry with government sponsorship, might be considered for the mental health field. Survey responses indicate that underprivileged neighborhoods have huge reservoirs of hidden human resources. In such neighborhoods, persons of low education have reached out successfully to give needed service to neighbors, playing a catalytic role in group educational and therapeutic programs. Former addicts, mental patients, alcoholics, have sufficiently aided themselves and fellow-sufferers so that there can be little question about the advisability of continuing and intensifying this form of non-professional utilization.

More active emphasis on recruiting volunteers from black as well as the white middle-class is another recommendation growing out of this survey. Affluence in itself does not lead toward the goal of genuine participation in the mainstream of society. Financially privileged citizens of diverse ethnic groups should be encouraged to join the ranks of those who enrich their own lives by volunteering to help their communities, and individual fellow-men in need.

Implications for Manpower and Mental Health Theory

Manpower theory is, at present, "a nebulous grouping of unsystematized conceptualizations." It is based on the ability to predict future social, demographic, economic, and psychological phenomena.[1] These variables are, indeed, in a state of constant flux. To compound the difficulties, concepts of prevention and treatment in mental health are changing, as are the interrelationships between broad demographic and related mental health phenomena.

In a democratic, peaceful nation, citizens must have considerable free choice as to where and at what they shall work. This places the burden on the government to develop plans for the design of suitable manpower objectives with sufficient built-in incentives to channel manpower into such significant areas as mental health. Comprehensive recruitment programs, grants for education, and in-service training for non-professional personnel can go a long way to provide meaningful incentives.

A fresh look will need to be taken at theory for improving divisions of labor between different levels of personnel. The unique-expedient dichotomy, found to be too simplistic in this research, could be dropped in favor of more dynamic theoretical considerations behind the use of non-professionals. Models which take into account the way in which mental health service changes as persons with different types of background and training join the team need to be developed.

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[1] Joseph A. Cavanaugh, Ph.D., "Mental Health Manpower Research," in Mental Health Manpower, Vol. II, op. cit., p. 104.

Emotional and social disturbances will be viewed increasingly as reactive to the total configuration of problems of living, best rectified with vast social and educational programs involving society as a whole. Social change and social action goals are not at all incompatible with the goals of prevention and treatment. Clinical and social systems theories can be studied with a view to integration.

As the public service system expands, need will be viewed increasingly as the only criterion for mental health care. This development may come as a direct result of a new appreciation of civil rights and the rights of the poor.

A beginning effort has been made in this study to specify goals and the interrelationships among other variables considered significant to prevention. The need to refine prevention theory has been addressed in the hope that others will continue along this path, clarifying and defining prevention so that the Nation can better plan comprehensive mental health programs attending to the whole range of health and illness. Perhaps, along this road, progress will evolve towards the goal of optimum mental health for all persons throughout their life cycle.

Models for Non-Professional Utilization

Conceptually, the following dimensions appear basic to projection of future models for non-professional utilization in mental health:

* Whether the task-function was previously performed by professionals, or not (i.e., by nobody);

* Whether the task requires professional training; and

* Whether simple transfer of the task (without change) is possible, or redefinition (change) in the nature of the task is implied.

Theoretically, all types of functions can be performed at all levels of prevention and treatment. Practically, however, certain models emerging from this study appear to lend themselves more readily to one or another preventive level.

1. Transfer of task model: assigning to the non-professional tasks, previously performed by professionals, which do not require professional training. Social workers and nurses are two professional disciplines whose jobs have long been plagued by considerable routine. Differential allocation of many resource-finding and care-taking tasks should free professional staff of functions which never properly belonged in the professional province.

2. Redefined task model: allocating to the non-professional a task rightly performed heretofore by professionals, but redefining the task in view of the special attributes or characteristics of the non-professionals. Many of the functions, reported to be performed by non-professionals in this research, fall into this category; that is, the push toward task re-allocation was highly expedient (lack of professional staff) but the task was modified as a safeguard to appropriate performance. The most common example of this model is the large number of non-professionals conducting group therapy or engaging in milieu therapy. The occupational therapy aide naturally uses the skills he has already acquired when he moved into conducting activity--group therapy for the mentally ill. Expectations of his performance are of a different level from those of a clinically trained professional.

3. Newly performed task model: assigning "new" (or rediscovered) tasks; that is, tasks not previously or recently performed by anyone, which do not appear to require professional training. These tasks can be designated and tailored to fit the characteristics and attributes of available non-professional workers. The popular "friendly companion" role performed by college student volunteers throughout this country, falls into this category. The "indigenous" family planning aide is another illustration of a more innovative task model essential to primary prevention.

In the provision of treatment and rehabilitation for the severely mentally ill (tertiary prevention), nursing aides, social work "associates," community mental health aides undoubtedly will continue to free professional staff in hospitals and clinics of traditional tasks not requiring their expertise. They will also be expected to continue to innovate with newer supportive tasks adapted to their highest potential abilities.

These models presuppose carefully tailored training programs, and supervision to enable the non-professional to contribute to the interdisciplinary team. Resistance needs to be overcome on the part of some professionals and administrators to involving the non-professional in the decision-making process.

To be effective, group counseling (which currently appears to be the method of choice in hospitals, clinics, in the corrections field and many mental health agencies) requires a certain minimum experience-level. Certain personality attributes, and skills are necessary for the interviewing tasks of all counseling and for dealing with "reality problems" which are considered the role of the non-professional. The novice in dealing with social interventions in mental health learns quickly that there are few easy "cases" or problems. Even assignments of parts of problems present difficulty for and challenge to the non-professional and the professional who delegates the assignment.

Education of Non-Professionals and Professionals

Much is being written today about the need for continuing education and career lines for non-professionals. Obviously this is an essential first step in implementing recommendations in non-professional utilization. Future employers should not need to report (as did some project directors) that they feel guilty about hiring non-professionals because the educational bureaucracies and the world of work will not credit their experience and allow them to move on to the next step of the mental health ladder. Individual mental health programs and state mental health agencies have begun to address the problem of finding ways to provide career ladders for non-professionals. These efforts are reflected in changes in educational and training programs for non-professionals.

Career-lines, based on the high school level through the community college and master's degree levels, are being developed by each of the professional core disciplines. Considering the breadth of functions being assumed by non-professionals, it would appear to be necessary to develop career lines in as broad a framework as possible--a community mental health framework which includes educators, social workers, psychiatrists, and others.

The ranks of the unskilled, untrained workers should become thinned by appropriate education and training programs. Hopefully, the term non-professionals will become obsolete as more positive titles--"community mental health worker" (trainee)--are appropriately designated. New professional groups--the mental health or community health professionals--should emerge from training programs which offer a master's or more advanced degree to those who ascend to the top of the mental health career ladder.

A key implication from this study for professional education is that greater clinical diagnostic and treatment skill would appear to be needed by the professional worker as he is relieved of certain time-consuming tasks not requiring professional expertise. New skills as community educators and organizers have to be taught to professionals to help them to function in preventive community roles. Additional functions of training and supervising non-professionals in their special roles, featuring the constructive use of relationship, social therapy, and community interactional techniques will need to be taken on by professionals in all mental health disciplines. The ability to teach basic concepts of human behavior on a level that is meaningful to persons of limited education will become a crucial task for the future. The trend is clearly towards greater sharing of knowledge between professionals and non-professionals.

Research

Future research is suggested in the following areas:

* Qualitative study of non-professional task-functioning; that is, evaluative study of how well non-professionals are performing the various functions described in this study. In this connection, it must be noted that evaluative studies of professional functioning are still in their infancy; this in no way diminishes the necessity for carefully planned evaluation of the functions assumed by non-professionals, particularly in relation to more recently performed functions.

* Qualitative research regarding professional--non-professional relationships and interaction patterns which evolve out of changing utilization of non-professionals.

* Inquiry into the effect of training on the "indigenous" worker.

* Systematic follow-up research of future employment of paid and volunteer non-professionals. As noted in study findings, rigorous follow-up of non-professionals' employment patterns, particularly of volunteer utilization, was minimal. This research will be needed to improve planning for career lines and ladders.

* Continued research into criteria for different utilization of different levels of staff.

Further research is suggested along the lines begun in this study to operationalize "prevention" and "innovation" in mental health. Implicit in this recommendation

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is the need for study of barriers to goal achievement at different preventive levels. Various human and technical obstacles--dearth of knowledge, resources, sanction, etc.--were identified, during site-visit interviews, as barriers to goal achievement.

Most strongly, of course, is cross-disciplinary epidemiological research indicated to discover the characteristics of high and low-risk populations in terms of predisposition to mental breakdown.

Conclusion

It would be difficult to single out the few most important findings and implications from this extensive survey. Among the central findings is the clear indication that the projects studied have demonstrated a massive change in staff patterns in the delivery of mental health services. Over 10,000 non-professional staff members were employed in the projects studied; several times in excess of the professional staff both in numbers and hours of service.

The sheer range of non-professional activities and the blurring of functional boundaries both within non-professional categories and between non-professional and staff categories is notable. The data suggest that non-professional tasks include those formerly carried by professionals, those not performed previously by anyone, and significantly those previously thought of as requiring professional competence but redefined in accordance with the special capacities of non-professional personnel.

Noteworthy, too, are the trends toward an increase in preventive activity and community involvement in this special group of projects. There are indications that new concepts of mental health and of the delivery of mental health services are in a process of development, and that these are related to the use of non-professional personnel.

Finally, both potentialities and problems are seen in the use of non-professionals. The balance is clearly weighted, however, in a positive direction. The overwhelming proportion of the projects surveyed believe that they could not have functioned without the non-professionals, and look forward to continuation and expansion of their use.

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